CHILD DEATH REVIEW TEAM

THE PROBLEM

Children are not supposed to die. When they do, their deaths are tragic events that affect whole communities. Especially tragic is a child death that could and should have been prevented. Each year, more than 400 Wisconsin children between one month and 17 years of age die. An additional 300 child deaths occur during the first month of life (Department of Health and Family Services). Approximately half of these unexpected deaths are preventable.

Most of these child deaths are "unexpected", that is, occurring in a child not known to be terminally ill. Some examples are unintentional injury, suicide, homicide, asphyxia, and infectious illness. Perhaps more than half of these are preventable,

THE GOAL: PREVENT CHILD DEATHS

We cannot turn back the clock on these deaths, but we can learn from each child death to help prevent future deaths. We owe it to the children and grieving survivors to try to understand what happened and how to prevent it from happening again. The Child Death Review Team (CDRT) is the mechanism for doing this because it is community-based, multidisciplinary, and confidential. Many factors exist that may affect a child's risk of death, and they are not all likely to be identified by one individual or agency. The Wisconsin Department of Health and Family Services and the State Department of Justice are collaborating to implement child death review teams in all counties of Wisconsin, thus joining the efforts of 49 other states.

THE KEY ELEMENT: THE LOCAL CHILD DEATH REVIEW TEAM

Juneau County established a child death review team in 2012, whereby we meet quarterly. The team agreed to review all deaths from ages 0-24, and consists of representatives from the Coroner's Office, law-enforcement, district attorney's office, area schools, Mile Bluff Medical Center, physicians, Human Services, Child Protective Services, Children's Health Alliance, and the Health Department, implementing the following objectives.

OBJECTIVES:

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.
2. Improve communication and linkages among local and state agencies, and enhance coordination of efforts.
3. Improve agency responses in the investigation of child deaths.
4. Improve agency responses to protect siblings and other children in homes of deceased children.
5. Improve criminal investigations and the prosecution of child homicides.
6. Improve delivery of services to children, families, providers, and community members.
7. Identify specific barriers and system issues involved in the deaths of children.
8. Identify significant risk factors and trends in child deaths.
9. Identify and advocate for needed changes in legislation, policy, and practices, and expanded efforts in child health and safety to prevent child deaths.
10. Increase public awareness and advocacy for the issues that affect the health and safety of children.